OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL DISCHARGE ABSTRACT DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with discharges on or after January 1, 2004

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97233)

1. TYPE OF CARE
1 Acute
3 SN/IC
4 Psychiatric
5 Chem Dep
6 Physical Rehab

1a. HOSPITAL NUMBER

17. ABSTRACT RECORD NUMBER (Optional)

2. DATE OF BIRTH
Month | Day | Year (4 - Digit)

20. PATIENT'S SOCIAL SECURITY NUMBER
(000 00 0001 If not recorded in the medical record)

3. SEX
1 Male
2 Female
3 Other
4 Unknown

4. RACE:

ETHNICITY
1 Hispanic
2 Non-Hispanic
3 Unknown

RACE
1 White
2 Black
3 Native American/ Eskimo/Aleut
4 Asian/Pacific Islander
5 Other
6 Unknown

5. ZIP CODE

6. ADMISSION DATE
Month | Day | Year (4 - Digit)

9. DISCHARGE DATE
Month | Day | Year (4 - Digit)

16. TOTAL CHARGES
(Report whole dollars only, right justified)

7. SOURCE OF ADMISSION:

SITE
1 Home
2 Residential Care Facility
3 Ambulatory Surgery
4 SN/IC
5 Acute Inpatient Hospital Care
6 Other Inpatient Hospital Care
7 Newborn
8 Prison/Jail
9 Other

LICENSURE OF SITE
1 This Hospital
2 Another Hospital
3 Not a Hospital

ROUTE
1 Your ER
2 Not Your ER (or no ER)

8. TYPE OF ADMISSION
1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

15. EXPECTED SOURCE OF PAYMENT:

PAYER CATEGORY
01 Medicare
02 Medi-Cal
03 Private Coverage
04 Workers' Compensation
05 County Indigent Programs
06 Other Government
07 Other Indigent
08 Self Pay
09 Other Payer

TYPE OF COVERAGE
1 Managed Care - Knox - Keene/ MCOHS
2 Managed Care - Other
3 Traditional Coverage

NAME OF PLAN
(0001 - 9999 Plan Code Number)

14. DISPOSITION OF PATIENT:

01 Routine (Home)
Within This Hospital
02 Acute Care
03 Other Care
04 SN/IC
To Another Hospital
05 Acute Care
06 Other Care (Not SN/IC)
07 SN/IC
08 Residential Care Facility
09 Prison/Jail
10 Against Medical Advice
11 Died
12 Home Health Service
13 Other

21. PREHOSPITAL CARE AND RESUSCITATION

DNR orders at admission or within 24 hrs of admission

Y = Yes
N = No

E - CODES:

18. PRINCIPAL E

19. OTHER E E E E

Be sure page 2 is copied on the reverse side!

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL DISCHARGE ABSTRACT DATA RECORD
SUPPLEMENTAL REPORTING PAGE

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10. PRINCIPAL DIAGNOSIS

CODE

10a. PRESENT AT ADMISSION

Y = Yes
N = No
U = Uncertain

11. OTHER DIAGNOSES

11a. PRESENT AT ADMISSION

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.
v.
w.
x.

12. PRINCIPAL PROCEDURE

CODE

DATE

Month | *Day* | *Year (4 - Digit)*

13. OTHER PROCEDURES

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.

Month | *Day* | *Year (4 - Digit)*

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DATA

INDIVIDUAL FACILITY TRANSMITTAL FORM

OSHPD Use Only

PM Date: _____

Agent: _____

Facility Name: _____

Facility Identification Number: | | | | | | |

Data Type: ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery

Report Period From: _____ to _____

Total Number of Records: _____

DISKETTE

☐ 3½" Diskette

☐ CD-ROM

Filename:

_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly
(Name of Facility)

authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the definitions of the required data elements in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this facility.

Dated: _____ By: _____
(Signature)

Facility: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

E-mail: _____

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DATA

DESIGNATED AGENT TRANSMITTAL FORM

OSHPD Use Only

PM Date: _____

Agent: _____

Agent's Name: _____

Contact Person: _____ Title: _____

Address: _____

Phone No: ( ) _____ Ext: _____

E-mail _____

DISKETTE

☐ 3½" Diskette

☐ CD-ROM

Filename:

_____

	FACILITY NAME	FAC. ID NO	DATA TYPE	REPORT PERIOD BEGIN	REPORT PERIOD END	TOTAL NO OF RECORDS
1.						
2.						
3.						
4.						
5.						

State of California – Health and Human Services Agency
Arnold Schwarzenegger, Governor

Office of Statewide Health Planning and Development
Healthcare Information Division
Patient Data Section
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679; Fax (916) 322-9555
www.oshpd.ca.gov/mircal

Agent Designation Form

In order to designate a third party agent to submit data on your behalf, your facility must complete this form. All information must be provided, including a signature from a facility administrator or primary contact.

Please print clearly

Section 1: Facility Information *(all information is required)*

1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. DATA TYPE(S): ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery Check one or more Data Type(s). *If none are checked, the Agent will be given access to all Data Types associated with your facility.*	
4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS):	
5. FACILITY CONTACT NAME:	6. TITLE:
7. PHONE:	8. E-MAIL ADDRESS:

Section 2: Designated Agent Information *(all information is required)*

9. NAME OF DESIGNATED AGENT (COMPANY NAME):	
10. BUSINESS ADDRESS (MAILING ADDRESS):	
11. CONTACT NAME:	
12. PHONE:	13. E-MAIL ADDRESS:
DESIGNATION EFFECTIVE DATE	
14. EFFECTIVE BEGIN DATE:	Designation is effective until OSHPD receives written notification of revocation or new designation.

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

15. NAME (PRINT):	16. TITLE:
17. SIGNATURE:	18. DATE:

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PATIENT DATA REPORTING EXTENSION REQUEST

Fax Request to: (916) 322-9555 Date: _____
Or (916) 327-1262
Attn: Patient Data Section

1. Facility Name: _____
2. Facility Identification Number: _____
3. Address: _____
4. Data Type:

- ☐ Inpatient
- ☐ Emergency Department
- ☐ Ambulatory Surgery

5. Report Period Begin Date: _____
6. Report Period End Date: _____
7. Designated Agent (if applicable): _____
8. Number of Extension Days Requested: _____
9. Person Requesting Extension (print): _____
10. Signature: _____
11. Title: _____
12. Phone: _____ E-mail: _____

User Account Administrator (UAA) Agreement

Please print clearly

Section 1: MIRCal User Account Administrator Information *(all information is required)*

1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. NAME (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS):	
4. POSITION (TITLE):	5. SUPERVISOR NAME:
6. BUSINESS ADDRESS (MAILING ADDRESS):	7. UNIQUE EMPLOYEE IDENTIFIER : *Note: An identifier that uniquely distinguishes you within your organization.*
8. BUSINESS PHONE:	9. BUSINESS FAX:
10. E-MAIL ADDRESS:	
11. AUTHENTICATION WORDS: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.*	
a. *Your mother's maiden name:*	b. *Your city of birth:*

I understand that as an appointed MIRCal User Account Administrator on behalf of the facility, I have the responsibility to:

1. Create/add and inactivate user accounts for other MIRCal users within my facility. Creating a user account includes granting access roles for an individual to read, submit and/or correct my facility's confidential data. Removing granted access roles and/or inactivating user accounts revokes this access.
2. Modify the demographic information for my facility's Primary, Secondary and Administrator Contacts. This notifies OSHPD of any changes in name, mailing address, phone number, and e-mail address for each contact. Modifying contact demographic information directly changes the information on the OSHPD database.
3. Change passwords for MIRCal users within my facility. In the event that a user misplaces or forgets their password, they will be directed to contact their User Account Administrator to have it reset. The User Account Administrator should authenticate the user prior to resetting the password and issuing a new password.
4. Unlock MIRCal user accounts. MIRCal will lock user accounts after three (3) unsuccessful log on attempts. When the account is locked, users will be required to contact their User Account Administrator to unlock their account.
5. Reactivate inactive accounts. NOTE: After 270 consecutive days (9 months) of inactivity, MIRCal user accounts may be inactivated.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

12. USER ACCOUNT ADMINISTRATOR SIGNATURE:	13. DATE:

Section 2: Facility Administrator Approval *(all information is required) To be completed by the Facility Administrator (CEO or equivalent)*

14. FACILITY ADMINISTRATOR NAME:	15. FACILITY ADMINISTRATOR SIGNATURE:
16. DATE:	17. PHONE NUMBER:

The completed form shall be sent to OSHPD for each User Account Administrator needing MIRCal UAA access. Fax (916) 327-1262 or (916) 322-9555

Section 3: For OSHPD use only

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

User Account Administrator (UAA) Agreement Instructions

Make a copy of the completed forms for your records. Send the completed form(s) to:

Office of Statewide Health Planning and Development
Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal

Contact Information
Call your OSHPD Analyst or (916) 324-6147
E-mail mircal@oshpd.ca.gov
Fax (916) 327-1262 or (916) 322-9555

SECTION 1: MIRCal User Account Administrator Information *(All fields must be completed) -- To be completed by the prospective MIRCal User Account Administrator.*

1. Facility ID Number: Provide your OSHPD assigned 6 digit facility number.
2. Facility Name: Provide the licensed name of your facility.
3. Name and Credentials: Provide your full name and credentials (if applicable).
4. Position (Title): Provide the position held at your facility.
5. Supervisor Name: Provide the name of your supervisor/manager.
6. Business Address (Mailing Address): Enter the business address where you can receive mail.
7. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
8. Business Phone: Provide a phone number where you can be contacted.
9. Business Fax: Provide a fax number where you can receive faxes.
10. E-mail address: Provide an e-mail address where you can be contacted.
11. Authentication Words: The authentication words provided may be used to identify you in the event that a password reset is required. It is important to remember this information.
    a. Provide your mother's maiden name.
    b. Provide your city of birth.
12. User Account Administrator Signature: If you acknowledge reading, understanding and agreeing to the contents of this document, provide your signature.
13. Date: Provide the date that the facility agreement was completed and signed.

SECTION 2: Facility Administrator Approval (*All fields must be completed) – To be completed by the Facility Administrator (CEO or equivalent). This should be the person who directs the overall management of the facility. OSHPD will cross reference this name against the name supplied by your facility as the MIRCal Facility Administrator contact person.*

14. Facility Administrator Name: Print your name.
15. Facility Administrator Signature: After you have reviewed and approved the completed Facility User Account Administrator Agreement, you must provide your signature indicating approval of person to act as the MIRCal User Account Administrator.
16. Date: Date of signature.
17. Phone Number: Provide a phone number where you can be reached.

SECTION 3: For OSHPD Use Only

Designated Agent User Agreement

Please print clearly

Section 1: MIRCal Designated Agent User Information *(all information is required)*

1. DESIGNATED AGENT NAME	
2. NAME OF MIRCAL DESIGNATED AGENT USER (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS):	
3. POSITION (TITLE):	4. SUPERVISOR NAME:
5. BUSINESS ADDRESS (MAILING ADDRESS):	6. UNIQUE EMPLOYEE IDENTIFIER: *Note: An identifier that uniquely distinguishes you within your organization.*
7. BUSINESS PHONE:	8. BUSINESS FAX:
9. E-MAIL ADDRESS:	
10. AUTHENTICATION WORDS: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.*	
a. *Your mother's maiden name:*	b. *Your city of birth:*

I understand that as a Designated Agent User:
1. I can submit data and retrieve the status of the data on behalf of a facility.
2. My MIRCal user account may be inactivated after 270 consecutive days (9 months) of inactivity. Only OSHPD can reactivate my account.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

11. DATE:	12. USER SIGNATURE:

Section 2: Designated Agent Primary Contact Approval *(all information is required)*

13. PRINT NAME:	14. DESIGNATED AGENT "*PRIMARY*" CONTACT SIGNATURE:
15. DATE:	16. PHONE NUMBER:

The completed form shall be sent to OSHPD for each Designated Agent user needing MIRCal access. Fax (916) 327-1262 or (916) 322-9555

Section 3: For OSHPD use only

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

Please Note: The Facility Administrator or Primary Contact at each facility that you represent must complete and sign the Agent Designation Form (OSHPD 1370.3) approving a Designated Agent to submit data on their behalf.

Designated Agent User Agreement Instructions

Make a copy of the completed forms for your records. Send the completed form(s) to:

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Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal

Contact Information
Call your OSHPD Analyst or (916) 324-6147
E-mail mircal@oshpd.ca.gov
Fax (916) 327-1262 or (916) 322-9555

SECTION 1: MIRCal Designated Agent User Information *(All fields must be completed) -- To be completed by MIRCal User requesting access to MIRCal.*

1. Name of Designated Agent: Provide the name of your business.
2. Name and Credentials of MIRCal Designated Agent User: Provide the full name of the MIRCal user and credentials (if applicable).
3. Position (Title): Provide the position held in your organization.
4. Supervisor Name: Provide the name of your supervisor/manager.
5. Business Address (Mailing Address): Enter the business address where you can receive mail.
6. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
7. Business Phone: Provide a phone number where you can be contacted.
8. Business Fax: Provide a fax number where you can receive faxes.
9. E-mail address: Provide an e-mail address where you can be contacted.
10. Authentication Words: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.*
    a. Provide your mother's maiden name.
    b. Provide your city of birth.
11. Date: Provide the date that the facility agreement was completed and signed.
12. User Signature: If you understand and agree with the responsibilities and guidelines for maintaining MIRCal security, as detailed in the user agreement, provide your signature.

SECTION 2: Designated Agent Primary Contact Approval *(All fields must be completed) – To be completed by the Designated Primary Contact.*

13. Print Name: Print the name of the Designated Agent Primary Contact.
14. Designated Agent Primary Contact Signature: When the completed information is reviewed and approved, provide your signature indicating approval of person to use MIRCal.
15. Date: Provide the date that this user agreement was approved and signed.
16. Phone Number: Provide a phone number where you can be reached.

SECTION 3: OSHPD Use Only

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No Data to Report

1. Facility Name: _____

2. Facility ID Number: | | | | | | |

3. We do not have data to report for the above mentioned facility for the following reason(s):

a) Hospital Inpatient Care:
Report Period: From _____ **to** _____
☐ We are not licensed to provide inpatient care effective: _____

☐ We are licensed for inpatient care for this report period, but did not have any discharges as defined in Section 97213(a) (1) of the California Code of Regulations.

b) Emergency Department:
Report Period: From _____ **to** _____
☐ We are not licensed to provide emergency department care effective: _____

☐ We are licensed for emergency department services for this report period, but did not have any encounters as defined in Section 97213(a) (2) of the California Code of Regulations.

c) Hospital-Based Ambulatory Surgery:
Report Period: From _____ **to** _____
☐ We did not perform procedures on an outpatient basis in a general operating room, ambulatory surgery room, endoscopy unit or cardiac catheterization laboratory as defined in Section 97213(a) (3) of the California Code of Regulations.

d) Freestanding Ambulatory Surgery Clinic:
Report Period: From _____ **to** _____
☐ We are not licensed by the State of California as a surgical clinic effective: _____

☐ We are licensed as a surgical clinic, but did not perform ambulatory surgery procedures for this report period, as defined in Section 97213(a) (3) of the California Code of Regulations.

4. Additional Explanation: _____

_____

_____

5. Submitted by:

_____ Print Name

_____ Title/Position

_____ Signature

_____ Date

_____ Telephone

_____ E-mail

"SAMPLE"
RACE/ETHNICITY FORM
(Courtesy of Fountain Valley Hospital Regional Medical Center)

Hospitals are required by law to provide the Office of Statewide Health Planning and Development (**OSHPD**) with information regarding the race and ethnicity of their patient population.

The mission of OSHPD is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of the people of California. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below:

ETHNICITY (Select One)

_____ HISPANIC: A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

_____ NON-HISPANIC Any possible options not covered in the above category.

_____ UNKNOWN A person who cannot or refuses to declare ethnicity.

RACE (Select One)

_____ WHITE A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

_____ BLACK A person having origins in or who identifies with any of the black racial groups of Africa.

_____ NATIVE AMERICAL/ESKIMO/ALEUT
A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

_____ ASIAN/PACIFIC ISLANDER
A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

_____ OTHER Any possible options not covered in the above categories. Includes patients who cite more than one race.

_____ UNKNOWN A person who cannot or refuses to declare race.